occurred before mid-1991. The information from the chief medical officers was issued in November 1991, and in Fife this does not seem to have been the main factor in promoting change. The health visitors attributed their change in practice to journal articles (59), the mass media (53), the west Fife sudden infant death syndrome project (43), the chief medical officers' circular (42), colleagues (31), personal interest (26), and their manager (21). This suggests that the professional press and general media are the most important influences (the west Fife project is a pilot study that used a risk score for the sudden infant death syndrome). The importance of these two types of media in influencing professional practice should not be underestimated and certainly in this instance seems to have been more important than, for example, briefings from managers.

This study shows that most health visitors in Fife have changed the advice that they give about the sudden infant death syndrome and that this seems to have been concurrent with the national decline in deaths from the syndrome (which seems to have begun at the end of 1990).[2] The link between these two observations is uncertain. It will be important to assess whether a similar change in parents' care of young children occurred over this period.

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1 Gordon RR. Postneonatal mortality in England, Wales, and Sweden. *BMJ* 1992;305:1095. (31 October.)
2 Registrar General for Scotland. Numbers of infant deaths in Scotland, with special reference to sudden infant death syndrome. *Vital Statistics Return* 1992;weeks 33-6.

Natural remedies

EDITOR,—Minerva[1] reported that a Chinese herbal remedy bought for the treatment of eczema was noted to contain as its active ingredient a potent steroid available only on prescription. Recently I was involved with an analagous case.

We saw a 54 year woman at the gynaecology clinic after an episode of postmenopausal bleeding. At dilatation and curettage histological examination showed "proliferative endometrial activity with focal decidual change whose features were consistent with exogenous hormonal stimulation." At her initial consultation she mentioned that she had consulted with a homoeopath for perimenopausal symptoms and that he had given her a remedy called APITOP-F.

She subsequently brought along the information leaflet, which stated that APITOP-F was a "vitamin-hormone" compound that in addition to helping most conditions was important in the treatment of "impaired potency from endocrine causes, climacteric complaints, cycle anomalies [and] frigidity." The list of ingredients, consisted mainly of vitamins but also included ethinyloestradiol 10 μg. The instructions for use stated that in the absence of any clear instructions from one's practitioner one could take the preparation once a day on a long term basis. No warning was mentioned. Ethinyloestradiol taken continuously effectively explained this woman's symptoms and pathology results. The danger of unopposed oestrogens in women who have an intact uterus are obvious.

These cases raise the question of the safety of such remedies, which seem to be outside the "prescription only medicine" status even though they contain as their active ingredients prescription only medicines.

The ethical nature of these remedies must also be questioned. Here are complementary medicines which contain conventional drugs as active ingredients. How many of these remedies actually contain such ingredients? Are there any complementary remedies for asthma that contain salbutamol? This area has potential for racketeers to use "Natural is best" (and almost by implication cannot cause harm) to market drugs under the banner of being natural remedies.

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1 Minerva. *BMJ* 1992;305:1514. (12 December.)

Sexual behaviour

EDITOR,—John Bancroft's editorial on research into sexual behaviour emphasises not only the current expansion in such research but also the practical difficulties in surveys that ask such personal questions.[1] Bancroft concludes that such research does not necessarily require large scale surveys and that reliability depends in part on there being a good, adequately explained purpose.

Increasing openness about the sexual activity of elderly people among the general public, support groups, and primary health care workers and in the media[2] has led to increasing demand for the investigation and treatment of impotence. Much of this demand has fallen on urology departments. Most recent studies on sexual functioning have concentrated on a younger cohort, the emphasis being the threat of AIDS. The study reported in the Kinsey report, the standard, included only two men over the age of 80.[3] I have just completed a face to face study of sexual functioning of 100 male urological patients over the age of 60 who were awaiting urological surgery for problems not related to impotence. Urology consultations, especially with discussion of possible postoperative urogenital problems, lead easily into such intimate questioning. Twenty of the 37 patients aged 60-69 with partners were sexually active, averaging coitus just less than once a week. Overall, 29 had complete erectile failure and nine were actively unhappy with their sex lives. The most important single factor determining sexual activity was the availability of a partner.

This study highlights the high level of sexual activity in some sections of the elderly population, which many young doctors regard as "sexless." Secondly, the findings concur with Bancroft's suggestions that if the techniques are suitable some valuable information can be obtained without large scale surveys.

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1 Bancroft J. Sexual behaviour in Britain and France. *BMJ* 1992; 305:1447-8. (12 December.)
2 Kellett JM. Sex and the elderly. *BMJ* 1989;299:934.
3 Kinsey AC, Pomeroy WB, Martin CE. *Sexual behaviour in the human male.* Philadelphia: Saunders, 1953.

EDITOR,—John Bancroft points out the difficulty in finding out the truth in surveys into sexual behaviour.[1] The new sex survey has fallen into the same trap that Kinsey *et al* and Schofield stumbled over in the 1950s and '60s[2,3]: it has produced results that are misleading in that they either greatly overestimate the number of partners of male heterosexuals or grossly underestimate those of women, or both. This could lead to policy on the spread of HIV being based on false information.

In all, the study found that men had three times as many partners as women: men had a lifetime average of 9·9 partners while women had an average of only 3·4. Such a discrepancy is logically impossible. As I have explained elsewhere, every time a woman has a new partner so does a man, and worldwide the total number of heterosexual partners must be equal.[4] The only way the figures from the latest survey could be true would be if men in the survey had had two thirds of their sexual partners outside Britain. In fact, evidence suggests that women not only have slightly more heterosexual partners than men but also begin their sexual activity younger. This is logical as women on average date and marry older men. When researchers have engaged in participant observation of youth instead of conducting their research by questionnaires they have usually confirmed that women started their sexual activity younger. For example, in his classic study of Elmstown's youth Hollingshead found that schoolgirls were about four times as likely to have sex as boys.[5]

One reason why sex surveys produce the wrong figures is that a man can gain status in his group by claiming to be sexually active. It is in casual sex that the widest discrepancies are likely to arise. Although there is not the shame associated with extramarital sex these days and over a third of births occur outside marriage, recent research I have carried out with young teenagers shows that there is still a prejudice against women having multiple sexual partners. Such behaviour by men is a sign of success.

I suggest that in future the way to get nearest to the truth about sexual behaviour is to ask men about their prior experiences and the age of their partners and work out the female data from this information. This would give rise to some problems in allowing for experience with foreigners and in correcting for male overstatement. I suspect, however, that it would allow the best opportunity for accurate data.

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1 Bancroft J. Sexual behaviour in Britain and France. 1992;305: 1447-8. (12 December.)
2 Kinsey A, Pomeroy WB, Martin CE, Gebhard PH. *Sexual behaviour of the human female.* Philadelphia: W B Saunders, 1953.
3 Schofield M. *The sexual behaviour of young people.* London: Longmans, 1966.
4 Francome C. *Abortion practice in Britain and the United States.* London and Boston: Unwin Hyman, 1986.
5 Hollingshead AB. *Elmstown youth.* New York: First Science, 1961:239.

Boxing injuries

EDITOR,—In answer to J E U Moxon's letter,[1] the BMA's opposition to boxing is based not on moral considerations but on the available medical evidence. The board of science and education's report on boxing due to be published in June reviews research carried out since the BMA's report on boxing in 1984.[2] This additional body of scientific evidence confirms that those who participate in boxing at amateur and professional levels are at considerable risk of sustaining chronic and acute brain injury. The association will therefore continue to monitor the evidence for the risks associated with boxing and to press for its abolition. I am sure that Moxon would wish the association to take all steps to prevent avoidable deaths and injury as part of its remit to highlight issues affecting the public health.

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1 Moxon JEU. Boxing injuries. *BMJ* 1992;305:1438. (5 December.)
2 Payne JP. *Boxing.* London: BMA, 1984.